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In The Supreme Court of the United States

October Term, 1987

NORTHERN GROUP SERVICES, INC., et al.,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., et al.,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTIONS PRESENTED

I.

Does the Employee Retirement Income Security Act (ERISA) preempt a State law which mandates that uninsured ERISA Plans be deemed "insurers" primarily liable for the payment of health and accident benefits contrary to the express provisions of the ERISA Plans, thereby imposing on ERISA Plans substantial administrative burdens and costs which are inconsistent from state to state and which those ERISA Plans never agreed to assume?

II.

If ERISA pre-empts the State law as applied to uninsured ERISA Plans, does it also pre-empt the State law as applied to uninsured ERISA Plans whose Plan Sponsors purchase "stop-loss" insurance to cover the Sponsors' potential funding liability to the Plan where the "stop-loss" insurance does not provide coverage of, or make payments to, the ERISA Plan or its participants or beneficiaries?

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

Petitioners pray that a writ of certiorari issue to review a judgment and opinion of the United States Court of Appeals for the Sixth Circuit, entered on November 13, 1987.

OPINIONS BELOW

The opinion of the Court of Appeals for the Sixth Circuit is reported at 833 F.2d 85, and is reprinted in the Appendix, p. 1b, *infra*.

The memorandum decision of the United States District Court for the Eastern District of Michigan (Taylor, D. J.) is reported at 644 F.Supp. 535, and is reprinted in the Appendix, p. 1a, *infra*.

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit was entered on November 13, 1987. On November 25, 1987, plaintiffs timely petitioned the Sixth Circuit for rehearing or for rehearing en banc. On December 30, 1987, the Sixth Circuit denied the petition for rehearing. Appendix, p. 1c, *infra*. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

This case involves Section 514 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. § 1144 (1982), and Section 3109a of the Michigan No-Fault Insurance Act, M.C.L.A. § 500.3109a. These provisions are reprinted in the Appendix, p. 1d, *infra*.

STATEMENT OF THE CASE

Petitioners (Plaintiffs-Appellees below) Masco Industries, Inc. Employees' Benefit Plans (the Masco Plans) and Highland Appliance Companies Medical Benefit Plan (the Highland Plan) provide medical and other benefits to employees. (The Masco Plans and the Highland Plan are referred to collectively as the "Petitioner ERISA Plans.") The employer/sponsors of these plans self-fund the benefits; they do not purchase insurance policies to pay plan benefits. Each plan is an "employee benefit plan" formed pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et. seq.*

Petitioner (Plaintiff-Appellee below) Northern Group Services (NGS) provides claims processing and other services for

the Petitioner ERISA Plans. NGS does not pay benefits out of its own assets, nor does it act as an insurer.

Automobile insurance companies in Michigan are required to offer no-fault automobile insurance coverage and to pay medical claims arising out of an automobile accident pursuant to M.C.L.A. § 500.3107.

If a participant in one of the Petitioner ERISA Plans is injured in an automobile accident and receives medical treatment for injuries suffered in that accident, the participant has two potential sources from which the medical expenses can be paid: (1) the automobile insurer and (2) the Petitioner ERISA Plan.

Many claims could be payable by the auto insurer but not by the medical plan. For example, the auto insurer is required to pay for certain rehabilitation costs, which are not covered by the Petitioner ERISA Plans. Similarly, the Petitioner ERISA Plans have a dollar limit on lifetime Major Medical claims. For example, they will not pay more than $100,000 in Major Medical claims over the lifetime of the covered individual. Auto insurers are required to pay all medical claims arising out of the automobile accident, without any limitation as to amount.

Precisely because the participants other sources of payment for various health and welfare benefits, each Petitioner ERISA Plan contains a "coordination of benefits" provision which expressly states when and how the Petitioner ERISA Plan will be liable if there are multiple potential benefits. The Masco Industries, Inc. Employees' Benefit Plan for Salaried Employees, for example, expressly makes the no-fault auto insurance the "primary" coverage and limits the Plan's liability to costs *not* covered by no-fault auto insurance.

The respondent automobile insurers also offer policies containing "coordination of benefits" provisions. Automobile insurers in Michigan are required to offer this "coordination of

benefits" option by M.C.L.A. § 500.3109a, which states in pertinent part:

> An insurer providing personal protection [automobile] insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident *coverage* on the insured. [Emphasis added.]

As its use of the word "coverage" emphasizes, M.C.L.A. § 500.3109a envisions and mandates that auto insurance benefits be coordinated only with other insurance benefits. Nonetheless, the respondents sought reimbursement from the Petitioner ERISA Plans for medical payments. In some cases respondents have sought reimbursement from NGS even though NGS merely processes claims for the Petitioner ERISA Plans and is not an insurer.

The respondents based their claims for reimbursement from the Petitioner ERISA Plans on cases interpreting M.C.L.A. § 500.3109a in the context of disputes between automobile and health insurers. In *Federal Kemper Ins. Co.* v. *Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W. 2d 590 (1986), the Michigan Supreme Court held, as a matter of law, that where there is both health insurance and no-fault automobile insurance, the health insurer is primarily liable for coverage of a claimant's medical expenses resulting from an automobile accident and the no-fault auto insurer is only secondarily liable. The insurers contended that Section 3109a means that no-fault automobile insurance must be secondary not only to health insurance but also to any other benefit source, including benefits under a self-funded ERISA plan. In other words, the auto insurers claimed that, for purposes of Section 3109a, the Petitioner ERISA Plans and other self-funded ERISA plans should be deemed to be health insurers.

To resolve this dispute, petitioners commenced an action in the United States District Court for the Eastern District of

Michigan seeking a declaration that the insurers' attempts to use Section 3109a to make claims against the Petitioner ERISA Plans was unconstitutional. Petitioners alleged that, as applied to a self-funded ERISA Plan, Section 3109a would "relate to" an ERISA employee benefit plan and, therefore, would be pre-empted by ERISA Section 514(a), 29 U.S.C. § 1144(a), and that Section 3109a could not be saved from pre-emption as a state insurance law because, under ERISA Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), the Petitioner ERISA Plans could not be deemed to be insurers.

Petitioners filed a motion for summary judgment or, in the alternative, a preliminary injunction, contending that there were no genuine issues of material fact with respect to their pre-emption claims. Certain respondents filed cross-motions for summary judgment contending, among other things, that the Highland Plan could not claim pre-emption because it was an "insured plan" within the meaning of ERISA, as construed by *Metropolitan Life Ins. Co.* v. *Massachusetts,* 471 U.S. 724 (1985).

The District Court granted petitioners' motion for summary judgment and denied respondents' motions for summary judgment. In its Memorandum Opinion and Order, the District Court held that ERISA did pre-empt Section 3109a as applied to ERISA employee benefit plans because the statute "relate[d] to" an employee benefit plan within the meaning of 29 U.S.C. § 1144(a). The District Court reasoned that, if Section 3109a was not pre-empted, "the State of Michigan would otherwise by its insurance laws be regulating federal ERISA plans and dictating when and to whom benefits should be paid . . ." and it concluded that "[c]ertainly this court cannot permit the State Legislature to intrude into an area which Congress specifically chose to leave open for private discretion." 644 F.Supp. at 538. The District Court also found that Section 3109a was not protected by the insurance savings clause in ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A),

because the Petitioner ERISA Plans could not be "deemed" an insurer by virtue of the "deemer" clause, 29 U.S.C. § 1144(b)(2)(B).

The Sixth Circuit reversed. It agreed that Section 3109a clearly "relate[d] to" the Petitioner ERISA Plans and, in fact, "conflicts directly" with these plans because "it allocates obligations to make insurance payments contrary to the express coordination-of-benefits language of the plan." 833 F.2d at 89. Nonetheless, the Sixth Circuit concluded that Section 3109a was saved from preemption by the insurance savings clause because Section 3109a "clearly 'regulates insurance' within the meaning of the savings clause" and "falls within the meaning of 'business of insurance' covered by the McCarran-Ferguson Act." 833 F.2d at 90. The Sixth Circuit also concluded that application of Section 3109a to ERISA plans was not barred by the "deemer clause." The Sixth Circuit recognized that *Metropolitan Life Insurance Co.* v. *Massachusetts,* 471 U.S. 724 (1985), had created "a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." It found that the Highland Plan could not be saved by the "deemer clause" because the employer purchased stop-loss insurance; and, therefore, it was, in effect, an insured plan. 833 F.2d at 91. Although the Masco Plan was totally self-insured, the Sixth Circuit concluded that the deemer clause did not bar state regulation of the Masco Plan. Since ERISA preserved "the principle favoring state regulation of insurance," it would be "contrary to the overall legislative purpose to read the deemer clause broadly to bar all state regulation of self-insured plans. In this area of traditional state regulation, 'the presumption is against pre-emption' . . . ." 833 F.2d at 92. The Sixth Circuit concluded that this "presumption" was not rebutted in this case because the state had a "strong, legitimate interest in keeping down the costs of [hospitilization] coverage and thus was justified in spreading the loss,

where there is multiple coverage, to entities other than no-fault insurers." 833 F.2d at 93. While it recognized that this would impose substantial administrative and financial burdens on ERISA plans, the Sixth Circuit concluded that such burdens would least disrupt "the state's ability to administer a uniform scheme of 'other-insurers' or 'coordination of benefits' law." 833 F.2d at 93. Since it could find no federal interest in uniformity in administration of ERISA plans which outweighed this "injury to the State scheme . . .," the Sixth Circuit refused to find that ERISA pre-empted Section 3109a. 833 F.2d at 93.

REASONS FOR GRANTING THE WRIT

I.

REVIEW IS NECESSARY TO RESTORE CONGRESS' PURPOSE TO ESTABLISH EMPLOYEE BENEFIT PLAN REGULATION AS AN EXCLUSIVELY FEDERAL CONCERN, TO ELIMINATE CONFLICTING STATE REGULATION OF EMPLOYEE BENEFIT PLANS AND TO RESOLVE A CONFLICT WITH DECISIONS OF OTHER CIRCUITS

The Sixth Circuit's decision is inconsistent with this Court's leading decisions on ERISA pre-emption; indeed, it destroys Congress' purpose to establish employee benefit plan regulation "as exclusively a federal concern." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98–99 (1983). The decision below is also inconsistent with decisions of other circuits. *See, e.g., Insurance Board Under Social Insurance Plan of Bethlehem Steel Corp.* v. *Muir*, 819 F.2d 408 (3d Cir. 1987); *Children's Hospital* v. *Whitcomb*, 778 F.2d 239 (5th Cir. 1985).

Last Term this Court succinctly but forcefully restated that ERISA's pre-emption provision was intended to "eliminat[e]

the threat of conflicting and inconsistent state and local regulation" of employee benefit plans. *Fort Halifax Packing Co.* v. *Coyne*, ____ U.S. ____, 96 L.Ed.2d 1, 10, 107 S.Ct. 2211 (1987), quoting Representative Dent. Similarly, in *Pilot Life Ins. Co.* v. *Dedeaux*, ____ U.S. ____, 95 L.Ed.2d 39, 46, 107 S.Ct. 1549 (1987), this court explained:

> . . . [T]he express pre-emption provisions of ERISA are deliberately expansive, and designed to "establish pension plan regulation as exclusively a federal concern. "* * * The House and Senate Sponsors emphasized both the breadth and importance of the pre-emption provisions. Representative Dent described the "reservation to Federal authority the sole power to regulate the field of employee benefit plans" as ERISA's "crowning achievement." [Citations omitted.]

See also ERISA Oversight Report of the Pension Task Force of the Subcommittee on Labor Standards, Committee on Education and Labor (Committee Print of Excerpts from H.R. Rep. No. 94-1785) ("Erisa Oversight Report"), p. 8 ("In electing deliberately to preclude state authority over these plans, Congress acted to insure uniformity of regulation with respect to their activities.")

Thus, as *Fort Halifax* noted, this Court has "not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements." 96 L.Ed.2d at 10. *See also Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981) ("This [pre-emption] provision demonstrates that Congress intended to depart from its previous legislation that 'envisioned the exercise of state regulation power over pension funds,' and meant to establish pension plan regulation as exclusively a federal concern.")

Notwithstanding the clear mandate in the statutory language, the legislative history and this Court's decisions,

the Sixth Circuit decision destroys any possiblity of uniformity and not only permits, but mandates, that ERISA plans be subjected to conflicting state regulations.

The Sixth Circuit acknowledged that Michigan's Section 3109a not only relates to the Petitioner ERISA Plans, but, in fact, "conflicts directly" with them by "allocat[ing] obligations to make insurance payments contrary to the express coordination-of-benefits language of the plan." 833 F.2d at 89. Indeed, as the Sixth Circuit recognized, Section 3109a mandates that an ERISA plan is primarily liable for health care costs even if the ERISA plan contractually agreed to pay health benefits only if the participant had no other source of insurance.

The Sixth Circuit nonetheless decided that, as applied to uninsured ERISA plans generally and the Petitioner ERISA Plans in particular, the State law cannot be pre-empted because subjecting ERISA Plans to state insurance regulation was more important than any arguable federal interest in uniform plan administration. In other words, faced with a direct conflict between an ERISA plan and a state law, the Sixth Circuit determined that the state law, not the provisions of the ERISA plan, should govern. In so deciding, the Sixth Circuit necessarily "dictate[d] what benefits should be paid under a plan," and thus it directly repudiated this Courts' numerous decisions that any state law mandating benefits should be pre-empted. *See Fort Halifax, supra,* 96 L.Ed.2d at n. 8 (describing a state mandated benefit law as "precisely the type of conflict that ERISA's pre-emption provision was intended to prevent").

Worse, because different states' insurance laws resolve insurance "coordination of benefit" provisions in a variety of ways, the Sixth Circuit necessarily requires employers to administer their plans differently in each state in which they have employees — a result which directly conflicts with the pre-emption provision's purpose to "ensure[] that the administrative practices of a benefit plan will be governed by only a

single set of regulations." *Fort Halifax, supra,* 96 L.Ed.2d at 11.

While the Sixth Circuit paid lip service to Congress' desire to ensure "a uniform scheme for coordinating complex administrative schemes, unaffected by divergent regulatory schemes in different states," 833 F.2d at 88, it then directly flouted the legislative intent by insisting that Congress' desire to ensure a uniform scheme for ERISA plan regulation was subordinate to Congress' desire to "preserve state regulation of insurance" and it held that state insurance laws could also bind self-insured ERISA plans notwithstanding the "deemer" clause in 29 U.S.C. § 1144(b)(2)(B), which expressly states that an employee benefit plan cannot be deemed to be "an insurance company or other insurer . . . or to be engaged in the business of insurance. . . ."

Having concluded that ERISA plans could be deemed "insurers" for purposes of state laws regulating insurance, and recognizing that its decision created the possibility of inconsistent state regulation, the Sixth Circuit then asked:

> . . . [S]hould interstate uniformity in the coordination of a plan's benefits with other insurance benefits override a state's traditional interest in a uniform rule for allocating comparative liability among all insurers [i.e. including ERISA plans which are deemed to be "insurers"]? [833 F.2d at 93]

The Sixth Circuit's answer to this question is shocking: It conceded that the courts could simply "defer willy nilly to the provisions of the ERISA plan," but it concluded that this would be "an obviously arbitrary result that would allow the plan trustees to decide every issue in their own favor without judicial review." 833 F.2d at 94.

The answer is shocking because it ignores Congress' clear mandate to allow ERISA plans to define the benefits and

obligations they are prepared to assume and because it glibly ignores the fact — emphasized by this court last Term in *Pilot Life, supra,* 95 L.Ed.2d at 50–51 — that ERISA Section 502(a) creates a comprehensive "civil enforcement scheme" to ensure that ERISA plan fiduciaries do not act arbitrarily.

It is even more shocking because its deference to state regulation rejects the fundamental premise of ERISA pre-emption: national uniformity. As the ERISA Oversight Report, p. 9, stated: " . . . [I]t is our finding that the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded."

Having concluded that state interests, not federal interests, should control conflicts between ERISA plans and state laws purporting to regulate ERISA plans, the Sixth Circuit then reiterated its holding that even self-insured ERISA plans are subject to state regulation unless they can demonstrate an "ERISA interest in uniformity" which outweighs a state's interest in regulating ERISA plans as if they were insurers. 833 F.2d at 94. But since the Sixth Circuit had rejected uniform administration itself as a sufficient ERISA interest, the Sixth Circuit virtually destroyed the effect of ERISA pre-emption and permits virtually complete state regulation of all ERISA plans including self-funded plans.

Thus, unless reversed, the Sixth Circuit's ruling will destroy the very purpose of ERISA pre-emption and make it impossible to administer any nationwide ERISA plan uniformly.

II.

REVIEW IS NECESSARY TO PREVENT THE SIXTH CIRCUIT'S DECISION FROM VOIDING THE EXPRESS PROVISIONS OF ERISA'S "DEEMER" CLAUSE

The Sixth Circuit justified its destruction of uniform plan administration by arguing that Congress' desire to preserve state regulation of insurance, as stated in the "insurance savings clause" of 29 U.S.C. § 1144(b)(2)(A), justified some state regulation of uninsured ERISA Plans. 833 F.2d at 92. In doing so, the Sixth Circuit effectively voided the express provisions of the "deemer" clause in 29 U.S.C. § 1144(b)(2)(B).

In *Metropolitan Life Ins. Co.* v. *Massachusetts,* 471 U.S. 724, 746–747 (1985), this Court recognized that Congress enacted the "deemer" clause to "modif[y] the insurance saving clause and thus created a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." In effect, as the 1977 Activity Report of the House Committee on Education and Labor explained,

> . . . the "deemed" language was utilized to create an irrebutable presumption that these plans are not insurance, trust companies, etc. for purposes of state regulation. . . . *The irrebutable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance, trust or securities activities generally regulated by any state.* [Emphasis added.]

The "deemer" clause reflects Congress' recognition that ERISA plans would engage in numerous activities which could be arguably characterized as "insurance" or the "business of insurance" within the meaning of McCarran-Ferguson Act and, therefore, that only an express statutory mandate that these activities not cause ERISA plans to be

treated as "insurers" would ensure that the threat of conflicting state regulation would be eliminated.

This distinction between "insured" and "uninsured" or "self-insured" plans has been accepted by every Circuit to consider the issue. *See, e.g., Children's Hospital* v. *Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Powell* v. *Chesapeake & Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, ____ U.S. ____ (1986); *United Food & Commercial Workers* v. *Pacyga*, 801 F.2d 1157 (9th Cir. 1986); *Insurance Board Under Social Insurance Plan of Bethlehem Steel Corp.* v. *Muir*, 819 F.2d 408 (3d Cir. 1987). Only the Sixth Circuit's decision reaches a contrary result; and it does so for reasons that turn the "deemer" clause on its head by concluding that ERISA plans could be "deemed" insurers for purposes of state insurance laws whenever "preemption of state law would substantially disrupt a state regulatory scheme generally applicable to both insured and self-insured ERISA plans, as well as to insurers generally. . . ." 833 F.2d at 95.

The Sixth Circuit, in effect, acknowledged that it was creating an unprecedented construction of the "deemer" clause which conflicted with decisions of this Court and virtually every other court to construe the "deemer" clause when it could cite only one decision to support its result — *Employers Association of New Jersey* v. *New Jersey*, 601 F.Supp. 232 (D.N.J.), *aff'd. mem.*, 774 F.2d 1151 (3d Cir. 1985). But that citation itself demonstrates the extent to which the Sixth Circuit has departed from the standards established by this and other courts. *Employers Association, supra,* confronted virtually the identical question which the court addressed in *Metropolitan Life;* and it held that a New Jersey statute which regulated the content of insurance policies (not ERISA plans) was not preempted by ERISA. The District Court expressly distinguished cases where state laws had been preempted because they "either directly or indirectly, purported to

regulate employee benefit plans and not solely to regulate insurance as in the instant case." 601 F.Supp. at 240.

In relying on such a slender reed, the Sixth Circuit demonstrated a disregard for the statutory language and the legislative history. Instead, it was engaged in an artful effort to create a role for state legislation directly contrary to Congress' intention. Indeed, the ERISA Oversight Report, pp. 9-10, commented on just such artful efforts:

> It has come to our attention that our efforts to ensure minimum disruption of the regulatory efforts of the states in the fields of insurance, banking and securities, generally are being construed as a reservation of state authority over employee benefit plans themselves. The argument is predicated on an interpretation of the language ". . . shall be deemed . . ." as used in section 514(b)(2)(B) to limit the scope of the prohibition contained therein to the use by State authority of a legal fiction to declare a plan to be insurance, or a trust company, etc., where it is not. As this line of reasoning goes, those plans which actually contain the characteristics of insurance, etc., would then remain subject to state regulation.
>
> Such interpretation, while artful, is not supported by a fair reading of the statute and legislative history.

III.

THE SIXTH CIRCUIT'S DECISION DESTROYS ANY POSSIBILITY OF ADMINISTERING ERISA PLANS BY REFERENCE TO PLAN DOCUMENTS AND MANDATES CASE-BY-CASE LITIGATION TO DETERMINE PLAN LIABILITY, THUS EFFECTIVELY DELEGATING RESPONSIBILITY FOR PLAN ADMINISTRATION TO THE COURTS

The Sixth Circuit's decision not only destroys uniformity; it makes it practically impossible for plan administrators to rely on the plan documents to administer ERISA plans. Instead, because it creates a balancing test which can only be applied on a case-by-case basis, the Sixth Circuit's decision virtually ensures constant litigation over the nature and extent of plan liability, thus effectively requiring courts, not plan administrators, to decide benefit claims.

This case provides a perfect example of the administrative dilemma created by the Sixth Circuit decision.

Both the Masco Plans and the Highland Plan have participants in numerous states. Indeed, virtually every sizeable ERISA plan has participants in many states because large employers do business across state lines. As the Sixth Circuit acknowledged, virtually every state has a statute or common law rule defining an insurer's obligations to coordinate benefits with other insurers. *See* 833 F.2d at 93. If, as the Sixth Circuit holds, an ERISA plan is simply another "insurer" within the meaning of those state laws, the plan administrator must evaluate each claim in the context of every state law which arguably impacts the claim for benefits.

Assume, for example, that a Masco employee in California is injured in an automobile accident in California. How does the plan administrator decide whether the Masco Plan bears

any liability for medical care? By pre-empting all state laws, Congress intended the question of benefits to be answered solely by reference to the plan documents. The Sixth Circuit, however, requires the plan administrator to examine the plan documents and California law and then to determine whether the interests served by California law outweigh the plan's interests. Since the plan administrator has fiduciary responsibilities to act fairly and can be found personally liable under ERISA § 502 if he decides incorrectly, one can reasonably expect him to avoid any decision of consequence by resorting to the courts for a declaration of rights. But even if he decides on his own, the plan administrator can expect to be challenged either by an auto insurer (as happened in this case) or by a plan participant. And the problem only gets worse. Consider, for example, the same Masco Plan administrator who now faces a claim by a Michigan resident involved in an automobile accident in California. The plan administrator now must not only weigh the competing interests of state law and ERISA Plan, he must also determine which state's interests should be weighed — in other words, he must become a choice of law expert as well.

Consider, finally, a plan administrator located in the Third, Fourth, Fifth or Ninth Circuit facing a claim by a Michigan resident involved in an accident, whether in Michigan or in California. Which Circuit's law should the administrator attempt to apply?

Examples could be multiplied. The three given, however, demonstrate why the Sixth Circuit's decision should be reversed and why this Court has repeatedly emphasized that ERISA pre-emption was enacted so that plan administrators — not state governments — could decide the nature and extent of benefits available to ERISA plan participants. *See Fort Halifax, supra,* 96, L.Ed.2d at 10.

To this point, we have only discussed the effect of the Sixth Circuit's decision on plan administration. It has an even more

deleterious effect on the financial integrity of the ERISA plans. The Sixth Circuit decision requires every ERISA plan having participants or beneficiaries in Michigan to assume new financial obligations for health benefits which were not contemplated when the plans were created and, indeed, which the plans themselves expressly refused to assume. Like the Masco Plan, many employers elect to provide health benefits only if the participant has no other source of health insurance benefits, such as those paid by automobile insurers. The Sixth Circuit decision makes those employers primarily liable for all health care costs of participants injured in automobile accidents — at least until the plan's assets or, perhaps, the sponsoring employer's assets, are exhausted. By transforming these ERISA plans from a secondary to a primary source of health care benefits, the Sixth Circuit has imposed a gigantic cost on ERISA plans which many may not be willing or able to afford. As a result, employers may be forced to reduce or eliminate health care benefits because, under the Sixth Circuit's decision, by agreeing to assume any liability for health care costs arising from an auto accident, ERISA plans are required to assume all liability. As an alternative, to pay the substantial additional cost of health care benefits, the employer may choose to eliminate other benefits that are already covered by the plans — benefits which may well be more desirable to the employees than the benefits mandated by Section 3109a.

In short, the Sixth Circuit's decision presents an employer with the very dilemma which Congress intended to eliminate when it enacted ERISA's broad pre-emption provision. A widely-cited law review article, cited with approval in *Shaw, supra,* 103 S.Ct. at 2901 n. 19, has described this dilemma very well:

> If states are permitted to require employee benefit plans to provide substantive benefits under the guise of insurance regulation, the result may be a Hobson's choice

for employer or labor and management negotiators: either abandon the funding of benefit plans through insurance policies or be willing to accept all encompassing uniform national contracts. For if each state may impose its own substantive terms on the plan, the only way uniformity may be reached is by incorporating into the plan all of the benefits each state requires. This dilemma is clearly of the type that Congress sought to avoid by enacting ERISA's pre-emption provisions, which were formulated to relieve interstate employee benefit plans of the adverse effects of cumulative or inconsistent state regulation. Hutchinson and Ifshin, *Federal Preemption of State Law Under the Employment Retirement Income Security Act of 1974,* 46 U. Chi. L. Rev. 23, 68–69 (1978).

Actually, the situation created by the Sixth Circuit's decision is much worse. The law review author assumes that uniformity could be achieved by "incorporating into the plan all of the benefits each state requires." *See also Fort Halifax, supra,* 96 L.Ed.2d at 10, discussing *Alessi, supra,* and *Shaw, supra.* But that simply is not possible in this case because state requirements themselves are inconsistent; and, therefore, no plan could avoid the administrative and financial burdens created by the Sixth Circuit's decision by simply adopting all state law requirements.

In summary, the Sixth Circuit decision has truly immense consequences for ERISA plans. If it is not reversed, those plans can no longer define their own benefits and administrative procedures; they become creatures of every state insurance law which, in the view of a court balancing the plan against state interests, is considered to be more important than the ERISA plan. That is precisely what Congress intended to prevent when it enacted ERISA Section 514.

IV.

REVIEW IS ALSO NECESSARY TO RESOLVE A CONFLICT WITH DECISIONS OF THE NINTH CIRCUIT AS TO WHETHER A PLAN SPONSOR'S PURCHASE OF STOP-LOSS INSURANCE CAUSES THE PLAN TO BECOME AN INSURED PLAN WITHIN THE MEANING OF *MASSACHUSETTS* V. *METROPOLITAN LIFE INS. CO.*

This court's decision in *Metropolitan Life* described a distinction between self-insured (or uninsured) and insured ERISA Plans. The Masco Plan is a self-insured plan. The Highland Plan is also self-insured; but the employer and plan sponsor purchased stop-loss insurance to provide protection for its funding obligations to the Highland Plan. The Highland Plan did not purchase the insurance; the Highland Plan remains solely responsible for the payment of plan benefits to participants; the employer's contributions to the plan are the sole assets of the Highland Plan; no participant or beneficiary has rights to receive payments from the insurer; and no insurance contract or policy would ever be involved in any claim by a participant or beneficiary against the Highland Plan. Petitioners thus argued that the Highland Plan should be deemed a self-insured plan within the meaning of *Metropolitan Life*. The District Court agreed. 644 F.Supp. at 538. But the Sixth Circuit disagreed and concluded that the Highland Plan was insured.

By its ruling, the Sixth Circuit created a conflict among the circuits which should be resolved by this court. *See* Supreme Court Rule 17.1(a). The Ninth Circuit has held that an employer's purchase of stop-loss insurance cannot make the plan an "insured plan" within the meaning of *Metropolitan Life*. *Moore* v. *Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986); *United Food & Commercial Workers* v. *Pacyga*,

801 F.2d 1157, 1161 (9th Cir. 1986); *see also Bone* v. *Association Management Services, Inc.*, 632 F.Supp. 493, 495 (S.D. Miss. 1986).

United Food & Commercial Workers perhaps best illustrates this conflict because it is directly contrary to the Sixth Circuit's decision on very similar facts. The Ninth Circuit held that an Arizona antisubrogation insurance law was preempted when applied to an ERISA Plan even though the ERISA Plan had purchased stop-loss coverage:

> The type of stop-loss insurance carried by the Plan herein cannot be termed health insurance, nor can it be said that the Plan is providing an insurance contract to its participants. The stop-loss coverage provides for payment to the Plan of up to $1.5 million to reimburse the Plan in the event that it must pay out more than a certain amount in claims in a given year. The stop-loss insurance does not pay benefits directly to participants, nor does the insurance company take over administration of the Plan at the point when the aggregate amount is reached. Thus, no insurance is provided to the participants, and the Plan should properly be termed a non-insured plan, protected by the deemer clause and preemptive of the Arizona antisubrogation law. 801 F.2d at 1161-1162.

Thus, this court should also grant the petition so that it can resolve this conflict and clarify the distinction between "insured" and "self-insured" ERISA plans which it made in *Metropolitan Life.*

CONCLUSION

For all these reasons, this Court should grant the petition so that it can establish the correct relationship between ERISA and state mandated benefit laws, reconcile the conflict in the lower courts, and forestall future adverse effects of such state statutes on employee benefit plans.

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DATED: March 25, 1988

No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1987

NORTHERN GROUP SERVICES, INC., et al.,
Petitioners,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE CO., et al.,
Respondents.

APPENDIX

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APPENDIX A

Memorandum Opinion and Order
June 11, 1986

(Filed June 11, 1986)
UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION
644 F.Supp.535

NORTHERN GROUP SERVICES, INC., et al.
Plaintiffs

v.

AUTO OWNERS INSURANCE COMPANY, et al.
Defendants.

Civ. No.
85-75383

MEMORANDUM OPINION AND ORDER

ANNA DIGGS TAYLOR, District Judge.

[536] This is an action for declaratory and injunctive relief. Plaintiff Northern Group Services, Inc. (NGS) is the Plan Supervisor for the plaintiff employee benefit plans; which include the Masco Industries, Inc. Employee Benefit Plan for Hourly Employees of Farming Technology; the Masco Industries, Inc. Employees' Benefit Plan for Salaried Employees; the Masco Industries, Inc. Self-funded Benefit Plans (the Masco Plans) and the Highland Appliance Companies Medical Benefit Plan (Highland Plan). These employee health and welfare benefit plans are subject to regulations contained in the Employee Retirement Income Security Act, 29 U.S.C. § 1132(e). This court also has jurisdiction pursuant to 28 U.S.C. §§ 1331, 2201-2202.

[537] The Plans provide health and medical benefits to the Plan participants and their beneficiaries. Their benefits include payment of medical, surgical, hospital, nursing and rehabilitative costs which result from injuries the participant

or beneficiary may suffer from an automobile accident. Each Plan contains a coordination of benefits provision which states that the Plan will be secondarily liable, after statutorily required no fault vehicle insurance coverage, for payment of benefits to such injured beneficiaries. The typical clause is found in the Masco Plan:

> If your state has a no-fault motor vehicle law, the coverage required by the state is considered primary for motor vehicle related medical expenses . . . Any eligible expenses which are not paid by that carrier will then be considered for payment by Masco Medical Plan. The Masco Medical Plan is considered secondary for no-fault motor vehicle expenses.

The defendants are seven insurance companies which provide medical insurance coverage for injuries related to automobile accidents: State Farm Mutual Automobile Insurance Company, Auto Owners Insurance Company, Auto Club Insurance Association, Farmers Insurance Exchange, Citizens Insurance Company of America, Michigan Mutual Insurance Company, and Allstate Insurance Company. These insurance companies do business in the State of Michigan. They have issued no-fault automobile insurance policies to Michigan residents pursuant to the provision of the Michigan No-Fault Automobile Insurance Act, M.C.L.A. § 500.3109a, which states that, when an insured is protected by other health and accident insurance coverage, a coordination of benefits policy must be offered to that insured: "[a]n insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates deductibles and exclusions reasonably related to other health and accident coverage on the insured."

Plaintiffs seek the adjudication of this court that M.C.L.A. § 500.3109a is preempted by ERISA; or alternatively, they

seek an order restraining defendants from claiming reimbursement from plaintiffs for the medical expenses which defendants have paid to beneficiaries of plaintiff ERISA plans pursuant to no-fault insurance policies. The parties have filed cross motions for summary judgment.

As a preliminary matter, defendant State Farm argues that plaintiffs lack standing to bring this claim. 29 U.S.C. § 1132(a)(3) provides that plan participants, beneficiaries and fiduciaries may bring an ERISA claim.

State Farm contends that plaintiff NGS, as Plan Administrator, lacks the discretionary control over the assets of these plans which is characteristic of true fiduciaries. ERISA defines a fiduciary as one who "exercises any discretionary authority or discretionary control respecting management of such plans or . . . disposition of its assets, he renders investment advice for a fee or other compensation . . . with respect to any moneys or other property, or he has discretionary authority or responsibility in the administration of the plan." 29 U.S.C. § 1002(2). Although William Alcott, III, the President of NGS, testified at his deposition that Masco Inc. retains substantial decisionmaking power over its plans, NGS as supervisor of the Plans, provides administrative services, such as the determination of claims, on the Plan's behalf. Moreover, under 29 U.S.C. § 1132(d)(1) this circuit has held that Plans may sue and be sued as an entity. *Saramar Aluminum Co. v. Pension Plan for Employees of the Aluminum Industry,* 782 F.2d 577, 581 (6th Cir. 1986). "The Plan, as the party before the court, necessarily includes those who must act for the Plan [such as NGS] to administer it and to effectuate its policies." *Id.* This court accordingly finds that plaintiffs do have standing to bring this action. Moreover, defendants themselves have sued NGS as administrator, so NGS does have a substantial stake in the outcome of this case.

NGS and the Plans argue here that M.C.L.A. § 500.3109a is a state law which "relates to" an employee benefit plan with [538] in the meaning of 29 U.S.C. § 1144(a) which provides that "the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." The term "relates to" has been interpreted by the United States Supreme Court to refer to any state law which has "a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983).

The No-Fault Act will accordingly be preempted unless, as defendants allege, it falls within the savings clause of ERISA. Section 1144(b)(2)(A) of ERISA provides that nothing in section 1144(a) shall be construed to exempt a state law which regulates insurance, banking or securities. However, section 1144(b)(2)(B) states that ERISA plans "shall not be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for the purpose of any law of any state purporting to regulate insurance companies." The Masco and Highland Plans do not provide insurance coverage for participants and they are not insurers within the meaning of ERISA or any other definition of that term, they merely pay benefits from a fund. There was argument here that plaintiff Highland Plan was an insured plan, as it has purchased some insurance. The United States Supreme Court has indeed defined an insured plan as one which purchases insurance for its participants. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 2385, 85 L.Ed.2d 728 (1985). The evidence clearly shows, however, that the insurance acquired by the Highland Plan is obtained to insure the Plan against the employer's failure or inability to make contributions to the Trust Fund.

The Michigan No-Fault Automobile Insurance Act is preempted to the extent that it has impact on the ERISA Plans. The applicable ERISA statute provides that all state laws which relate to employee benefit plans are superseded by ERISA. 29 U.S.C. § 1144(a). Therefore, plaintiffs claim, section 500.3109a is preempted by ERISA because the State of Michigan would otherwise by its insurance laws be regulating federal ERISA plans and dictating when and to whom benefits should be paid by federally authorized fiduciaries. It appears to the court that the conclusion of preemption is mandatory in this instance because to allow the State of Michigan to control payment of federal benefits would be contrary to Congress' intent to "occupy [that] field." *Ogden v. Michigan Bell Tele. Co.*, 571 F.Supp. 520, 523 (E.D. Mich.1983). Congress has determined that private fiduciaries are to administer such plans in their discretion, in accordance with certain federal policies. To permit the state also to regulate distribution of the assets of those same plans would inevitably result in thwarting Congressional policy and would also discourage employers from establishment of new plans. Congress did not see fit to dictate payment of any specific benefits after full consideration of that alternative. It chose to free the fiduciary from arbitrary constraints. The Supreme Court directed questions concerning the wisdom of that intent directly to Congress. *Metropolitan Life*, 105 S.Ct. at 2385. Certainly this court cannot permit the State Legislation to intrude into an area which Congress specifically chose to leave open for private discretion.

Case law requires this conclusion. In *Children's Hospital v. Whitcomb*, 778 F.2d 239,242 (5th Cir. 1985), another declaratory judgment action, the hospital sued for a determination regarding the meaning and application of provisions of its self-insured Employee Welfare Benefit Plan under

ERISA. A member of the hospital's Plan was treated in Louisiana for mental and emotional disorders. The Plan limited payment for such treatment to $50,000 and she demanded full payment. The hospital administrator denied the request.

The Louisiana statute provided that the plans must pay benefits for mental or nervous disorders under the same conditions as they pay benefits for other treatment. The Court of Appeals for the Fifth Circuit af[539]firmed the district court's decision that ERISA mandates that private ERISA plan provisions must control and supersede conflicting state law. The court made its ruling based upon an analysis of ERISA's preemption, insurance savings and deemer clauses. It held that "ERISA preempts the Louisiana statute insofar as it relates to a self-insured plan, although it would not preempt if the plan were an insured plan." *Id.* at 242. This distinction was also made by the *Metropolitan Life* Court. 105 S.Ct. at 2393.

The factual situation of *Auto Club Ins. Asso. v. Pipeline Industry Benefit Fund,* ____ F.Supp. ____ CA No. 85-70415 (E.D.Mich. 12/13/85) (Cook, J.), is remarkably similar to this case. In *Auto Club Ins.*, the plaintiff insurer had paid medical expenses of its insured and sued the Plan for reimbursement under the coordinated benefit statute — M.C.L.A. § 500.3109a. Two of the issues before that court were whether M.C.L.A. § 500.3109a relates to the Plan and whether section 500.3109a is exempt from ERISA preemption principles.

The court held that section 500.3109a would, if given effect, directly regulate the uninsured Pipeline Benefit Fund and was accordingly preempted. The savings clause will only save state laws regulating commercially insured plans from preemption.

Defendants also argue that Michigan law controls here because the parties are estopped from denying their contractual agreement that "to the extent not inconsistent with

Federal law the Plan shall be interpreted under the laws of Michigan." But defendants fail to recognize that section 500.3109a does indeed conflict with ERISA, a federal statute. The Masco Plan in this case expressly provides that payment of benefits will be secondary to coverage which may be required by the state. The other plans incorporate similar language.

The No-Fault Act, according to defendant, raises Plan status to that of primary liability. It would be highly inconsistent with federal law to permit such a reading to govern. The principles of estoppel are also inapplicable under these circumstances.

Defendants also allege that two of the Plan's members must have misrepresented that they had other insurance coverage to the insurance agent because otherwise, a coordination of benefits policy could not have been written. Allegedly, the agent relied upon this misrepresentation; and the policy was *void ab initio.* No estoppel or misrepresentation can be inferred by any of the undisputed facts and no dispute exists as to any material fact. This record reflects only that plan beneficiaries disclosed their status as such to the insurers.

Finally, defendant Farmers Insurance Exchange protests that it should not have been named as a defendant in this case because it has not made any claims against plaintiffs. Thus, Farmers claims that there is no case or controversy as to it. The court finds that there is indeed no justiciable controversy as to Farmers Insurance Exchange because it has not filed any claims against plaintiffs. The court may not issue advisory decisions for hypothetical situations or instances in which a party anticipates a cause of action. *Caldwell v. Craighead,* 432 F.2d 213, 218 (6th Cir.1970) 28 U.S.C. §§ 2201-2202 cloaks this court with jurisdiction only "in a case of actual controversy within its jurisdiction. . . ." That controversy must exist

on the date the complaint is filed. Accordingly, the complaint as to Farmers Insurance Exchange is dismissed.

IT IS THEREFORE ORDERED that, for the reasons outlined above, M.C.L.A. § 500.3109a is preempted by ERISA and plaintiffs' motion for summary judgment is granted.

IT IS FURTHER ORDERED that Farmers Insurance Exchange's motion to dismiss is granted and the complaint as to Farmers Insurance is dismissed.

IT IS SO ORDERED.

APPENDIX B

Opinion of the Court of Appeals
November 13, 1987

(Decided November 13, 1987)

NOS. 86-1614, 86-1615, 86-1616
UNITED STATES COURT OF APPEALS,
SIXTH CIRCUIT
833 F.2d 85

NORTHERN GROUP SERVICES, INC., et al.,
Plaintiffs-Appellees,

v.

AUTO OWNERS INSURANCE COMPANY, et al.,
Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN

BEFORE: MERRITT and MARTIN, Circuit Judges, and BROWN, Senior Circuit Judge

MERRITT, Circuit Judge

[86] A group of automobile insurance companies challenge a ruling on summary judgment that the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq.*, preempted the Michigan No-Fault Automobile Insurance Act, Mich. Comp. Laws § 500.3109a, to the extent that the Michigan law allows policy provisions which conflict with ERISA plans. ERISA's preemption provision, 29 U.S.C. § 1144(a), provides in relevant part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this

> chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .

The Michigan statute requires that no-fault automobile insurers offer coordination of benefits provisions, and state court interpretation of that law makes the liability under such no-fault coverage secondary to other health and accident coverage. The plaintiff plans make no-fault liability primary and their own liability secondary and hence conflict with the Michigan insurance law. We reverse, holding that the Michi[87]gan law is saved from preemption by the ERISA "savings" clause, 29 U.S.C. § 1144(b)(2)(A),

> Except as provided in subparagraph (B) nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities,

and is not barred by the "deemer" clause, 29 U.S.C. § 1144(b)(2)(B),

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts. . . .

The questions of preemption analysis and interpretation under the first preemption clause, § 1144(a), and the savings clause are straightforward and not particularly difficult. The questions under the "deemer" clause are more complex.

I. Proceedings Below

Several ERISA plans that provide employee health and medical benefits brought this declaratory action in the District Court seeking injunctive relief from medical expenses paid

under no fault insurance policies by those companies to those covered by the ERISA plans. The ERISA plans contain coordination of benefits provisions that purport to make the liability of the plans secondary to state mandated no-fault automobile insurance. The Masco plan for salaried employees provides:

> If your state has a no-fault motor vehicle law, the coverage required by the state is considered primary for motor vehicle related medical expenses. If you or a covered dependent incurs medical expenses as a result of a motor vehicle accident, those expenses should first be submitted to your motor vehicle insurance carrier. Any eligible expenses which are not paid by the carrier will then be considered for payment by the Masco Medical Plan. The Masco Medical Plan is considered secondary for no-fault motor vehicle expenses.

The automobile insurance companies defending the claims have issued no-fault automobile insurance contracts in accordance with Mich.Comp.Laws § 500.3109a. The Michigan law "mandates that no-fault carriers offer coordination of benefits at reduced premiums when the insured has 'other health and accident coverage.'" *Federal Kemper Insurance Co. v. Health Insurance Administration, Inc.*, 424 Mich. 537, 546, 383 N.W.2d 590, 594 (1986). In *Federal Kemper* the Supreme Court of Michigan determined that section 3109a imposed primary liability on a health insurer when the insured also had a no-fault policy with a coordination of benefits clause and the no-fault insurer charged lower premium rates. Relying on section 3109a and *Federal Kemper*, the automobile insurance companies have made claims against the employee benefit plans for reimbursement, asserting that they, not the plans, are secondarily liable.

In order to settle this confusion over the coordination of benefits between the plans and the statutorily required no-fault coverage, the plans and a plan administrator brought a declaratory action. After discovery, the parties made cross motions for summary judgment. The District Court held that ERISA preempted the Michigan law because the Michigan law "relate[d] to" an employee benefit plan within the meaning of 29 U.S.C. § 1144(a). *Northern Group Services v. State Farm Mutual Automobile Insurance Co.*, 644 F.Supp. 535 (E.D.Mich.1986). Further, the Michigan law was not protected by the savings clause, § 1144(b)(2)(A), because the plans were excluded by the deemer clause, § 1144(b)(2)(B). Because the plans were protected by ERISA, Michigan could not regulate the benefits they provided. The District Court concluded that "[t]he Michigan No-Fault Automobile Insurance Act is preempted to the extent that it has an impact on the ERISA plans." *Id.* at 538. The Court granted plaintiffs' motion for summary judgment and denied defendants' cross motion.

II. "Relate To"

As was inevitable with such broadly phrased statutory language, the extent of [88] the preemption provision has been the subject of much litigation.

Shaw v. Delta Air Lines, 463 U.S. 85, 96-98, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490 (1983), made clear that a law "relates to" an employee benefit plan if it has "a connection or reference to such a plan." The Court based this reading not only on a plain meaning approach but on the expressed legislative intent giving the words "relate to" a broad scope. Id. at 97-98, 103 S.Ct. at 2900. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), held that a state law requiring that health insurers

provide mental-health-care benefits "clearly" relates to ERISA welfare benefit plans. *Id.* at 739, 105 S.Ct. at 2389.

In *Fort Halifax Packing Co. v. Coyne*, ____ U.S. ____, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987), the Supreme Court further considered the meaning of the phrase "relate to any employee benefit plan." In *Fort Halifax* a Maine official sought to enforce the state statute requiring employers, in the event of a plant closing, to provide a one-time severance payment to employees not covered by express contract agreements providing for severance pay. The Court held that the Maine severance pay statute did not "relate to any employee benefit plan" under the ERISA preemption provision, 29 U.S.C. § 1144(a), and thus was not preempted. Relying on the meaning and underlying purpose of section 1144(a), the Court rejected Fort Halifax's argument that any state law pertaining to a type of employee benefit listed in ERISA, such as severance pay, necessarily regulates a plan and is preempted.

Section 1144(a), the Court noted, expressly states that state laws are superseded to the extent they "relate to any employee benefit *plan*." The Court said that the preemption provision "does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit *plans*'." *Id.* at 107 S.Ct. at 2215 (emphasis original). The Court observed that ERISA uses the words "benefit" and "plan" separately throughout and nowhere treats the two as synonymous. "Given the basic difference between a 'benefit' and a 'plan,' Congress' choice of language is significant in its pre-emption of only the latter." *Id.* at 2216.

The Court identified the purpose of the preemption provision: to allow plans to adopt a uniform scheme for coordinating complex administrative activities, unaffected by divergent regulatory schemes in different states. Congress was aware of the administrative realities faced by employee benefit plans,

and sought to "eliminat[e] the threat of conflicting or inconsistent State and local regulation." *Id.* (*quoting* 120 Cong.Rec. 29197 (1974) (remarks of Rep.Dent)). The Court explained that any employer who undertakes systematically to pay certain benefits assumes a number of obligations such as ascertaining eligibility, determining benefits, making payments, monitoring the availability of funds for benefit payments, and keeping records in compliance with reporting requirements:

> The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

Id. Thus, ERISA's preemption provision was designed generally to "ensure [] that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Id.* at 2217.

The analysis in *Fort Halifax* does not affect the result here. *Fort Halifax* held that a Maine state law requiring a *one-time* severance payment when a plant is closed did not "relate to" any *plan* because it imposed no continuing administrative obligation. The Court described the state-law [89] obligation as one "[t]o do little more than write a check." Under the *Fort Halifax* circumstances, preempting state law to clear the way for exclusive federal regulations would "in no way serve the overall purpose of ERISA," because "there would be nothing to regulate." *Id.* at 2218, 2220.

By contrast, the Michigan coordination-of-benefits law imposes not a one-time duty but rather a continuing and predictable obligation to coordinate benefits with the other insurance coverage of all ERISA beneficiaries. Affected ERISA administrators would be required to "foresee the need to make regular payments . . . on an ongoing basis," *Fort Halifax,* 107 S.Ct. at 2219 n. 9, and to make appropriate actuarial (and cost) adjustments.

In summary, the Michigan law conflicts directly[1] with the plan: it allocates obligations to make insurance payments contrary to the express coordination-of-benefits language of the plan. Holding that this state law does not "relate to" the plan would run contrary to the plain meaning of the text and to the relevant case law and legislative history.

Because this state law "relates to" ERISA plans, we must proceed to see what effect the "savings" and "deemer" clauses have on preemption.

III. "Savings" and "Deemer" Clauses

The difficult problem in interpreting the preemption portion of ERISA § 514, 29 U.S.C. § 1144 is defining the scope of each of the three critical clauses so that each has meaning and so that benefit obligations are governed by a rational system of state law and federal common law. Congress indicated its intention only in a very general way and left to the federal courts the problem of developing on a case-by-case basis principles of preemption of state law.

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[1] The exception for "too tenuous, remote, or peripheral" regulation created in *Shaw,* 463 U.S. at 97 n. 17, 103 S.Ct. at 2900 n. 17, thus is inapplicable here. *Cf. Firestone Tire & Rubber Co. v. Neusser,* 810 F.2d 550, 553-56 (6th Cir. 1987).

If the first preemption clause, § 1144(a), is read restrictively, the "savings" and "deemer" clauses become unnecessary. Compounding the difficulty is a tendency in the legislative history of ERISA to conflate and confuse the three clauses. For example, an oversight report issued three years after the enactment of ERISA cites the need "to insure uniformity of regulation" by legislating preemption but then says:

> There was a recognition of the necessity for the preservation of some State activity in this field and certain limited exceptions were made to the broad preemption scheme. *In general these exemptions are designed to save State law as it applies to entities which are not employee benefit plans . . ., to the extent that such regulation does not relate to employee benefit plans.*
>
> • • •
>
> These exceptions are designed to delineate affirmatively the limits of the "field" preempted by section 514(a), and articulate a second, but distinctly subordinate, policy within the section of preserving state authority *insofar as it does not relate to any plan. . . .*

ERISA Oversight Report of The Pension Task Force of the Subcommittee on Labor Standards, House Committee on Education and Labor, at 8-9 (1977) (emphasis added).

These subsequent legislators (or their staff) did not seem to recognize or consider the fact that the "savings" clause would not be necessary at all if it only saves state laws that do not "relate to" ERISA plans. The savings clause would not be necessary to save something that the preemption clause had not reached in the first instance. *See Metropolitan Life,* 471 U.S. at 739-40, 105 S.Ct. at 2389.

A. "Savings" Clause

After preempting state laws that "relate to" plans, the "savings" clause provides the qualification that preemption does not apply to a state law that "regulates insurance, banking, or securities." Like the mandated-benefits act at issue in *Metropolitan Life Insurance Co. v. Massachusetts,* the Michigan coordination of benefits law controls the terms of insurance contracts. [90] The Michigan law clearly "regulates insurance" within the meaning of the savings clause. This conclusion comports both with a common sense view of the statutory language and with a more formal assessment that the practice falls within the meaning of "business of insurance" covered by the McCarran-Ferguson Act. *Metropolitan Life,* 471 U.S. at 740–43, 105 S.Ct. at 2389-91.

In order to satisfy a common sense understanding of the phrase "regulates insurance," a state law must have not merely an impact on the insurance industry, but must be specifically directed toward that industry. *Pilot Life Insurance Co. v. Dedeaux,* ____ U.S. ____, 107 S.Ct. 1549, 1554, 95 L.Ed.2d 39 (1987). The Michigan coordination of benefits law obviously is principally directed at various types of other-insurance coverage held by all of its residents who elect the coordination of benefits option that is mandated by § 3109a. Mich.Comp.Laws 500.3109a.

Three criteria have been identified as relevant to the McCarran-Ferguson Act determination:

> (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry.

Metropolitan Life, 471 U.S. at 743, 105 S.Ct. at 2391 (quoting *Union Labor Life Insurance Co. v. Pireno,* 458 U.S. 119, 129, 102

S.Ct. 3002, 3008, 73 L.Ed.2d 647 (1982)). Like other courts that have applied these criteria to coordination-of-benefits or similar requirements, we find the first two of the three criteria easily satisfied. The practice of coordination of benefits spreads risk and regulates permissible terms of the insurance contract. *See, e.g., United Food & Commercial Workers v. Pacyga,* 801 F.2d 1157, 1161 (9th Cir.1986); *State Farm Mutual Insurance Co. v. American Community Mutual Insurance Co.,* 659 F.Supp. 635, 637 n. 2 (E.D.Mich.1987).

Although the scope of § 3109a extends beyond traditional insurance to encompass other types of "health and accident coverage" including Blue Cross and Blue Shield benefits and health maintenance organizations,[2] the third McCarran-Ferguson Act criterion also is substantially satisfied because coordination of benefits is aimed principally at different types of *insurance* coverage. *See LeBlanc v. State Farm Mutual Auto Insurance Co.,* 410 Mich. 173, 301 N.W.2d 775, 784–85 (1981).

B. "Deemer" Clause

The Michigan coordination of benefits law "regulates insurance" and therefore is encompassed by the savings clause. The final question becomes: what is the effect of the "deemer clause"?

1. The Problem of Self-Insuring Plans

Most judicial interpretation of the deemer clause as an exception to the savings clause has been confined to a distinction

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[2] *See, e.g., LeBlanc v. State Farm Mutual Automobile Insurance Co.,* 410 Mich. 173, 301 N.W.2d 775 (1981) (Medicare); *United States Fidelity & Guaranty Co. v. Group Health Plan,* 131 Mich. App. 268, 345 N.W.2d 683 (1983) (health maintenance organization); *Nyquist v. Aetna Insurance Co.,* 84 Mich.App. 589, 269 N.W.2d 687 (1978) (Blue Cross & Blue Shield), *aff'd,* 404 Mich. 817, 280 N.W.2d 792 (1979).

which makes the deemer clause applicable to self-insuring ERISA plans and makes it inapplicable to plans that purchase insurance. Even direct regulation of the content of insurance policies that an ERISA plan purchases is not barred by the deemer clause. Regulation of the insurance contract or of the insurer from which the plan buys its policy does not entail treating or deeming *the plan* as an insurer or as otherwise in the "business of insurance." *See Metropolitan Life,* 471 U.S. at 735 n. 14, 742 n. 18, 105 S.Ct. at 2387 n. 14, 2390 n. 14; *Michigan United Food & Commercial Workers Unions v. Baerwaldt,* 767 F.2d 308, 312-13 (6th Cir.1985) *cert. denied,* 474 U.S. 1059, 106 S.Ct. 801, 88 L.Ed.2d 77 (1986).

The *Metropolitan Life* Court appeared in dicta to assume that this distinction would leave insured plans "open to indirect regu-[91]lation" by state insurance laws while leaving self-insured plans unregulated. In *Metropolitan Life,* the Court upheld under the savings clause state laws which "mandate" that specific benefits be included in group health plans. No question was presented under the deemer clause. As an aside the Court observed:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

471 U.S. at 747, 105 S.Ct. at 2393. At that point the Court dropped the following footnote:

> A 1977 Activity Report of the House Committee on Education and Labor recognized the difference in treatment between insured and non-insured plans: "To the extent that [certain programs selling insurance policies] fail to meet the definition of an 'employee benefit plan'

> [subject to the deemer clause], state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these 'products.'" H.R.Rep. No. 94–1785, p. 48. A bill to amend the savings clause to specify that mandated-benefit laws are preempted by ERISA was reported to the Senate in 1981 but was not acted upon.

Id. at 747 n. 25, 105 S.Ct. at 2393 n. 25.

Our consideration of the deemer clause, thus, must answer two questions. First, are the plans at issue "insured"? Second, if a plan is not "insured," is state regulation of coordination of benefits under the plan totally barred by the deemer clause? In other words, is the deemer clause a total bar to state regulation of any insurance provision of a self-insured plan even though the deemer clause would not preempt state law if the plan is funded through the purchase of insurance?

There is no dispute that the Masco Plans are self-insured; the parties disagree about the status of the Highland plan, which is covered by stop-loss insurance. Appellee plans argue that the Highland Plan is "uninsured" because (1) the actual insured is the employer, Highland Appliance Co., and not the Plan; and (2) the insurer's liability comes into effect only when specified benefit ceilings are exceeded. Both arguments are without merit. Whether the actual insured is the employer or the ERISA plan, the stop-loss insurance is purchased to "provide benefits for plans subject to ERISA." *Metropolitan Life,* 471 U.S. at 738 n. 15, 105 S.Ct. at 2388 n. 15. That the Plan pays a deductible does not alter the fact that benefits payable above specified levels, either on an individual beneficiary or in the aggregate, are nonetheless insured. *See Baerwaldt,* 676 F.2d at 313.

The Masco plans, however, apparently are totally self-insured. Are they thereby totally immune from traditional

state insurance regulation? Upon full consideration of the statutory scheme, we conclude that they are not.

Although Congress delcared its express intention to generally preempt state law in the preemption clause, 29 U.S.C. § 1144(a), it equally expressly declared its intention to preserve state regulation of insurance in the savings clause, 29 U.S.C. § 1144(b)(2)(A). Therefore, in determining the scope even of express ERISA preemption, the general principle still applies that a court "must presume that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life,* 471 U.S. at 740, 105 S.Ct. at 2389 *(Citing Jones v. Rath Packing Co.,* 430 U.S. 519, 525, 97 S.Ct. 1305, 1309, 51 L.Ed.2d 604 (1977)).

This presumption receives specific reinforcement from two subsections in § 514. ERISA section 514(d) says:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States. . . .

29 U.S.C. § 1144(d). This subsection provides an independent source of protection to state insurance regulation by including [92] in its coverage the McCarran-Ferguson Act, which says:

> The business of insurance, and every person engaged therein, shall be subject to the laws of the several states which relate to the regulation or taxation of such business.

15 U.S.C. § 1012(a); *see Metropolitan Life,* 471 U.S. at 744 n. 21, 105 S.Ct. at 2392 n. 21; *see also Shaw,* 463 U.S. at 101 n. 22, 103 S.Ct. at 2902 n. 22.

Section 514(d) makes no specific reference to the McCarran-Ferguson Act. Section 514(b)(2)(B), however, by

using the phrase of art, the "business of insurance," makes clear that the scope of state insurance regulation saved by the "savings" clause must include the "business of insurance" as defined by the McCarran-Ferguson Act.

In the face of this redoubled statutory preservation of the principle favoring state regulation of insurance, it appears contrary to the overall legislative purpose to read the deemer clause broadly to bar all state regulation of self-insured plans. In this area of traditional state regulation, "the presumption is against pre-emption." *Metropolitan Life,* 471 U.S. at 741, 105 S.Ct. at 2390; *see also Wadsworth v. Whaland,* 562 F.2d 70 (1st Cir.1977), *cert. denied,* 435 U.S. 980, 98 S.Ct. 1630, 56 L.Ed.2d 72 (1978).

The legislative history behind the deemer clause is ambiguous. As the Court observed in *Metropolitan Life,* the preemption sections "are not a model of legislative drafting" because "while Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time." 471 U.S. at 739–40, 105 S.Ct. at 2389.

Before conference, the House and Senate versions of the bill preempted only those state laws that related to the "fiduciary, reporting and disclosure responsibilities" of the Act or that related to "the subject matter regulated" by the Act. Both versions saved state insurance regulation, but neither contained a "deemer" clause until the House substituted the text of H.R. 12906 for that of H.R. 2 just prior to passage of the pre-conference House bill. *See* Subcomm. on Labor of the House Comm. on Labor and Public Welfare, 94th Cong., 2d Sess., Legislative History of the Employee Retirement Income Security Act of 1974, at 2671, 2921. Before conference, the committee staff, noting the difference between the House and Senate versions on the "deemer" clause reported itself divided on whether "the House provisions should be adopted" and

recommended that, if it were, adoption be for only a limited period of time and subject to subsequent study. *Id.* at 5283. The conference version of the bill broadened preemption, retained the deemer clause without any time limit, and mandated Congressional study of "the effects and desirability of the Federal preemption of State and local law with respect to matters relating to pension and similar plans." 29 U.S.C. § 1222.

In 1977, the Activity Report of the House Committee on Education and Labor expressed the opinion that

> the "deemed" language was utilized to create an irrebuttable presumption that these plans are not insurance, trust companies, etc. for purposes of state regulation. As a drafting technique the "deemed" is used in section 514(b) not to *bar* the use of a legal fiction by the states but to *create* what may amount to a legal fiction in a given circumstance. The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance, trust, or securities activities generally regulated by a state.

ERISA Oversight Report of the Pension Task Force of the Subcommittee on Labor Standards, House Committee on Education and Labor, at 10 (1977) (emphasis in original). This *post hoc* explanation, while interesting, is entitled to little weight when it conflicts with a reasonable interpretation of a statute based on its text and its legislative history prior to enactment. *See Consumer Product Safety Commission v. GTE Sylvania,* 447 U.S. 102, 117-18 & n. 13, 100 S.Ct. 2051, 2060-61 & n. 13, 64 L.Ed.2d 766 (1980).

[93] Certain aspects of the legislative history imply that a main concern of Congress in adopting the final broad version of section 514 that emerged from the conference committee

was to avoid intentional — and perhaps pretextual — attempts by states to restrict the discretion of ERISA plans to engage in practices that otherwise would be permitted by federal law.[3] *See American Progressive Life & Health Insurance Co. v. Corcoran,* 715 F.2d 784, 787 (2d Cir. 1983). Neither intention nor pretext, however, is raised by the state regulation here.

2. State and Federal Interests

A conflict between two coordination of benefits clauses, as here, invokes a large body of substantive law that has developed over time to resolve such conflicts, law based on principles of restitution as applied in the insurance context. *See, e.g.,* 8A Appleman, *Insurance Law & Practice* §§ 4906-23; 44 Am.Jur.2d, *Insurance* §§ 1781-93. The Michigan legislature and courts simply have superimposed upon this body of law a reasonable policy judgment that a conflict between benefits available under no-fault and other benefits should be resolved in favor of the no-fault insurer. This resolution eliminates duplication of recovery by the insured and furthers the twin purposes of § 3109a to contain both auto insurance costs and health insurance costs. *See Federal Kemper Insurance Co. v. Health Insurance Administration, Inc.,* 424 Mich. 537, 383 N.W.2d 590, 596 (1986).

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[3] *See Metropolitan Life,* 471 U.S. at 745-46 & nn. 23-24, 105 S.Ct. at 2392 & nn. 23-24. This view is reinforced by the language of the deemer clause itself, which protects ERISA plans from being "deemed" insurers or otherwise in the business of insurance by any state "purporting" to regulate insurance. 29 U.S.C. § 1144(b)(2)(B). Sponsoring senators expressed their satisfaction that states would be barred from frustrating Congressional intent by the "*guise* of state-enforced professional regulation" or by "state laws hastily *contrived* to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the federal regulatory scheme. *See* 12 Cong. Rec. 29,933 (Sen. Williams); 120 Cong.Rec. 29,942 (Sen. Javits) (emphases added).

Neither the principal purpose nor the main effect of the Michigan coordination of benefits law is to restrict the range of options open to ERISA plans. The State legislature and its courts simply have decided that medical expenses resulting from an auto accident should be paid first by those who have specifically insured the medical risk in the form of health and hospitilization coverage rather than by the no-fault insurance liability carrier. Auto no-fault coverage is compulsory, and the State therefore has a strong, legitimate interest in keeping down the costs of this coverage. This interest is not likely to be exercised in a parochial or discriminatory way. When there is multiple coverage, loss simply is first spread to entities other than no-fault insurers. ERISA plans are treated no differently than other entities providing "coverage."

In the absence of a showing of state purpose specifically to regulate the content of welfare benefits provided by ERISA, the effect of the deemer clause should be assessed by a balancing of the interests in federal uniformity against those of state primacy in the regulation of insurance. Put another way, should interstate uniformity in the coordination of a plan's benefits with other insurance benefits override a state's traditional interest in a uniform rule for allocating comparative liability among all insurers? Which principle of uniformity is the least disruptive and the most likely to create the orderly system of reliable benefits that Congress had as its object in enacting ERISA?

Exemption of the Masco Plan and other self-insurers from the Michigan rule of *Federal Kemper* would disrupt the State's ability to administer a uniform scheme of "other-insurance" or "coordination of benefits" law. Not only would exemption frustrate the goal of cost containment, it would also create unpredictability and possibly undermine the financial stability of no-fault insurers.

Against this injury to the State scheme, we must weigh the federal interest in uniformity of administration of ERISA plans. The question is whether ERISA plan provi[94]sions for coordination of benefits should receive a uniform national construction.

3. The Proper Role of Federal Common Law

One "uniform rule" would be simply to defer willy nilly to the provisions of the ERISA plan, an obviously arbitrary result that would allow the plan trustees to decide every issue in their own favor without judicial review. The other alternative would be for the federal courts to develop an entire body of federal common law to resolve "other insurance" disputes between ERISA plans and other insurers on a case-by-case basis — an approach that would be inefficient and uninformed by any well-defined independent federal interest.

Over the years states, including Michigan, have developed a substantial and complex body of common law and statutory principles to resolve questions of priority that arise when multiple coverage produces conflicts of the type presented in this case. This corpus of law embodies principles of restitution and risk allocation that have evolved from acquired state experience and expertise. Although these rules may be imperfect and display some minor variation from state to state, in the aggregate they nonetheless represent an interconnected and complex network of generally applicable laws with which the nation's insurers have grown familiar. *See, e.g.*, 8A Appleman, *Insurance Law & Practice* §§ 4906–23.

Although the drafters of ERISA clearly contemplated and invited the development of federal common law[4] to fill gaps

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[4] Sen. Javits remarked: "It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong.Rec. 29,942.

resulting from ERISA's broad preemption of state law outside the insurance field, it is less than clear that this would be a salutary development in an area that would overlap and inevitably conflict with established state insurance jurisprudence. In the absence of any particular federal interest in uniformity that would inform the development of federal common law on this issue, what federal common law we might develop surely would mostly parrot the principles already developed by the state courts. Moreover, application of a federal rule of common law here would trigger a substantial risk of "disrupt[ing] commercial relationships predicated on state law." *West Virginia v. United States,* ____ U.S. ____, 107 S.Ct. 702, 705, 93 L.Ed.2d 639 (1987) (quoting *United States v. Kimbell Foods, Inc.,* 440 U.S. 715, 729, 99 S.Ct. 1448, 1459, 59 L.Ed.2d 711 (1979)).

This entire scenario would undermine the general authority and autonomy the states now enjoy in their regulation of insurance. In view of the expressed intent of Congress and of the Supreme Court that ERISA should be read consistently with the policies underlying the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.,* there is strong reason to respect the policy choice and expertise of the state of Michigan in the area of coordination of benefits.

Accordingly, we read the "deemer" clause no more broadly than the underlying purpose of § 514 and of ERISA as a whole — the interests of national uniformity.[5]

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[5] *See* 120 Cong.Rec. 29,942 (remarks of Sen. Javits): "[T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required — but for certain exceptions — the displacement of State action in the field of private employee benefit programs."

This approach better reconciles the competing national policies favoring (1) comprehensive federal regulation of employee benefit plans and (2) state primacy in the regulation of insurance. Nor is this approach necessarily inconsistent with the dicta in *Metropolitan Life* concerning insured versus self-insuring plans.[6] 471 U.S. at 740–41, 747, 105 S.Ct. at 2389–90, 2393. We [95] preserve a distinction between insured and self-insuring plans. Insured plans would be *per se* "open to indirect regulation." *Id.* at 747, 105 S.Ct. at 2393. Self-insuring plans would be subject to state regulation only when no independent federal interest in national uniformity exists to inform and guide the creation of federal common law. *See Mardan Corp. v. C.G.C. Music, Ltd.*, 804 F.2d 1454, 1457–58 (9th Cir.1986); *Textile Workers Union v. Lincoln Mills*, 353 U.S. 448, 457, 77 S.Ct. 912, 918, 1 L.Ed.2d 972 (1957); *cf. Wilson v. Garcia*, 471 U.S. 261, 105 S.Ct. 1938, 85 L.Ed.2d 254 (1985).

Our reading of the savings and deemer clauses thus requires at a minimum that, for the deemer clause to override the savings clause in a given case, there must be some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance. When, as here, there is no demonstrated interest in national uniformity and preemption of state law would substantially disrupt a state regulatory scheme generally applicable to both insured and self-insured ERISA plans, as well as to insurers generally, the deemer clause does not bar regulation. To this limited degree,

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[6] In *Pilot Life Insurance Co. v. Dedeaux*, 107 S.Ct. at 1555, the Court construed the sweep of the savings clause as a whole and in light of the object and policy underlying ERISA, thus going beyond the meaning imposed merely by application of the McCarran-Ferguson Act factors. We take the same approach here to reconciliation of both the savings and deemer clauses.

self-insured ERISA plans so regulated are not excluded from the savings clause by the deemer clause; they are thus subject to state insurance regulation pursuant to the savings clause. The Michigan no-fault coordination of benefits rule is the type of insurance regulation of an ERISA plan that is not barred by the deemer clause. We find support for this result in *Employers Association v. New Jersey,* 601 F.Supp. 232 (D.N.J.) (state coordination of benefits not barred by the deemer clause), *aff'd mem.,* 774 F.2d 1151 (3d Cir. 1985) (post-*Metropolitan Life*); *contra State Farm Mutual Insurance Co. v. American Community Mutual Insurance Co.,* 659 F.Supp. 635 (E.D.Mich. 1987).

The judgment below is therefore reversed and the case remanded to the District Court for further proceedings not inconsistent with this opinion and with the Michigan law as enunciated in *Federal Kemper. See Federal Kemper,* 424 Mich. 537, 383 N.W.2d at 596 n. 10.

APPENDIX C

Order of the Court of Appeals
denying Petition for Rehearing en banc
December 30, 1987

No. 86-1614/5/6

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NORTHERN GROUP SERVICES, INC., et al.,
Plaintiffs-Appellees,

v.

STATE FARM MUTUAL AUTOMOBILE INS., CO., et al.,
Defendants,

AUTO OWNERS INSURANCE CO., et al.,
Defendants-Appellants.

ORDER

The Court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this Court, an no judge of this Court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ John P. Hehman, Clerk

APPENDIX D

Relevant Statutory Provisions

I. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
29 U.S.C. Section 514

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

II. MICHIGAN NO-FAULT INSURANCE ACT M.C.L.A. § 500.3109a

500.3109a. Deductibles and exclusions relating to other health and accident coverage

Sec. 3109a. An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The

deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.